STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

CALIFORNIA STATE ATHLETIC COMMISSION
1424 HOWE AVE. STE. #33
SACRAMENTO, CA 95825
INTERNET: www.dca.ca.gov
(916) 263-2195 FAX (916) 263-2197

PRE-FIGHT MEDICAL QUESTIONNAIRE

Contestant's Name: _____

Personal physician contact information:

Name:_____

_____
Address City State Zip Telephone number

Have you ever had a MRI Scan? ☐ **YES** ☐ **NO** If yes, please give date and the reason why:
_____

Have you ever had a neuromuscular condition, including peripheral nerves, muscle or brain problems?
☐ **YES** ☐ **NO** If yes, please explain: _____
_____

Have you ever had an EEG? ☐ **YES** ☐ **NO** If yes, please give date and the reason why:_____
_____

Have you ever had an EKG? ☐ **YES** ☐ **NO** If yes, please give date and details:_____
_____

Have you ever had any heart or cardiovascular condition? ☐ **YES** ☐ **NO** If yes, please give date and details: _____

Have you ever had any broken bones or arthritis? ☐ **YES** ☐ **NO** If yes, please give date and the details:
_____

Have you ever had any ophthalmologic (eye) problems? ☐ **YES** ☐ **NO** If yes, please give date and the details: _____

Have you suffered any eye injuries or had any eye problems since your yearly ophthalmologic examination? ☐ **YES** ☐ **NO** If yes, please give the details:_____
_____

Have you ever had any hearing problems? ☐ **YES** ☐ **NO** If yes, please give date and the details:
_____

Have you ever had any pulmonary or respiratory condition? ☐ **YES** ☐ **NO** If yes, please give details:
_____

Have you ever had any renal or urological condition? ☐ **YES** ☐ **NO** If yes, please give date and details:
_____

Have you ever had a hematological condition or any unusual bleeding or bruising problems? ☐ **YES** ☐ **NO**
If yes, please give details: _____
_____

Have you suffered from any serious illness, disease or allergy? ☐ **YES** ☐ **NO** If yes, please give the details: _____

_____

Are you taking any prescribed medications? ☐ **YES** ☐ **NO** If yes, please list:_____

_____

Are you taking any over-the-counter medications? ☐ **YES** ☐ **NO** If yes, please list.:_____

_____

When was the last time you took any type of medication or drug? _____
What type and when: _____

When was the last time you took any type of vitamin supplement? _____
What type and when: _____

Have you had any surgeries? ☐ **YES** ☐ **NO** If yes, please list: _____

_____

Have you had any lacerations (cuts) requiring sutures? ☐ **YES** ☐ **NO** If yes, please list: _____

_____

Have you suffered any knockouts (KO's), technical knockout's (TKO's), of loss of consciousness in the last six (6) months during a fight or sparring? ☐ **YES** ☐ **NO** If yes, please list: _____

_____

How much did you weigh when you began training for this bout? _____ Two weeks ago? _____

Did you take any medication or vitamin supplement to help you loose weight since you began training for this bout? ☐ **YES** ☐ **NO** If yes, please give date(s) and details:_____

_____

_____

When was your last bout, and what were the results of the fight? _____

……

If any condition is disclosed under this paragraph, the physician shall not allow the contestant to compete unless the physician or, at the contestant's discretion, the contestant's personal physician, who is licensed to practice medicine in the United States, has conducted a physical examination and determined that the specific condition does not affect the contestant's ability to perform or present a potential threat to the contestant's health as a result of competing in the contest or match.

I, _____, CONTESTANT, declare under penalty of perjury under the laws of the State of California, that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

COMMISSION PHYSICIAN ADMINISTERING PHYSICAL:

_____ _____

NAME **SIGNATURE**

DATE:_____ **TIME:**_____